

Provision of Community Benefits among Tax-Exempt Hospitals: A National Study

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## **ABSTRACT**

**Background:** We conducted a national study of the level and pattern of community benefits that tax-exempt hospitals provide. The Patient Protection and Affordable Care Act (ACA) requires tax-exempt hospitals to conduct community needs assessments every three years and address identified needs. Hospitals must initially meet this requirement sometime between 2013 and 2014 depending on when their fiscal year begins.

**Methods:** The study population comprised over 1800 tax-exempt hospitals, approximately two-thirds of all such institutions. We used reports that hospitals filed with the Internal Revenue Service for fiscal year 2009 that provide expenditures for seven types of community benefits. We combined these reports with other sources of hospital data to examine whether institutional and community characteristics are associated with hospitals' provision of community benefits.

**Results:** Tax-exempt hospitals spent approximately 7.5 percent of their operating expenses on community benefits. Approximately 85 percent of these expenditures were devoted to charity care and other patient-care services. Of the remaining community benefit expenditures, approximately 5 percent were devoted to community health improvements that hospitals undertook directly. The rest went to education for health professions, research, and contributions to community groups. Substantial variation existed among hospitals in terms of the level of benefits provided (hospitals in the top decile devoted 20% of operating expenses on community benefits; hospitals in the bottom decile devoted 1%). This variation was not accounted for by indicators of community need.

**Conclusions:** In 2009 tax-exempt hospitals varied markedly in the level of community benefits provided with most of their benefit-related expenditures allocated to patient care services.

Relatively little was spent on community health improvement.

A long standing policy issue in the US concerns tax exemption for nonprofit hospitals. Almost all such hospitals are exempt from income, property, and sales taxes on the basis that they qualify as charitable organizations.<sup>1-3</sup> Although federal, state, and local standards for defining a charitable organization differ in many cases, there is a general expectation that tax-exempt hospitals will benefit their communities by providing services and otherwise engaging in activities that they fully or partially subsidize.

However, whether tax-exempt hospitals provide appropriate levels of community benefit has generated considerable controversy. At the local level, a number of hospitals have had their property tax exemptions challenged or revoked on the ground that the community benefits they provide are inadequate.<sup>1,4-6</sup> At the federal level, several congressional hearings have been held to address whether tax-exempt hospitals are sufficiently accountable for providing community benefits at levels that justify the value of their federal income-tax exemption,<sup>7</sup> which according to the Government Accountability Office (GAO) is approximately \$13 billion annually.<sup>8</sup> These hearings provided the impetus for Congress to add provisions to the Patient Protection and Affordable Care Act (ACA), the country's sweeping health care reform law, that requires tax-exempt hospitals to conduct a community needs assessment every three years and develop an implementation strategy to address identified needs.<sup>9</sup> Hospitals must initially meet this requirement sometime between 2013 and 2014 depending on when their fiscal year begins.

This controversy has also motivated empirical studies of the provision of community benefits by tax-exempt hospitals.<sup>2,3,8,10</sup> Most such studies have been confined to certain states and to a narrow set of community benefit measures. Although more comprehensive studies are needed to assess the provision of community benefits among tax-exempt hospitals, such research

has been impeded by a lack of uniform, national data and a common methodology for defining and measuring community benefits. A major step toward addressing these limitations occurred in 2007 when the IRS revised Schedule H of Form 990 to promote uniform and comprehensive reporting of community benefits.<sup>1</sup> All tax-exempt organizations are required to complete Form 990 but Schedule H pertains specifically to hospitals. The revised Schedule H requires hospitals to report their expenditures for activities and services that the IRS has classified as community benefits. The revised version of Schedule H includes specific criteria and instructions for reporting these expenditures so that information should be comparable among hospitals. Hospitals were first required to file this revised form in 2009.

We used information from the 2009 revised Schedule H to conduct a national study of the provision of community benefits by tax-exempt hospitals. We combined this information with other data sources to address three questions. First, from a national perspective what is the level and pattern of community benefits provided by tax-exempt hospitals? Second, how much variation exists among tax-exempt hospitals in the level of benefits provided? Third, is the variation among tax-exempt hospitals associated with institutional-level and community/market-level characteristics?

## **METHODS**

**Study Population and Data:** Our study focused on tax-exempt hospitals that provide general, acute care services. These organizations represent over 90 percent of all tax-exempt hospitals.<sup>11</sup> All tax-exempt hospitals are nonprofit and non-governmental institutions.

We conducted our investigation using several data sources. Our primary source of data consisted of Form 990 and related Schedule H for 2009 (see online supplement). We focused on 2009 as it was the first year in which the IRS required hospitals to file the revised Schedule H and for which the reported information was most complete as many hospitals receive extensions to file these forms each year. We obtained these data from Guidestar Inc, a company that obtains, digitizes, and sells data that organizations report on Form 990 and related schedules. For each tax filing we obtained from Guidestar, we confirmed that the Form 990 and Schedule H belonged to a tax-exempt hospital by matching the hospital's name and address with information contained in the 2009 American Hospital Association's (AHA) Annual Survey of Hospitals.

Following these procedures, we were able to assemble a study population of over 1800 hospitals, which based on the 2009 AHA Survey represents approximately two-thirds of all tax-exempt hospitals that provide general, acute care services. The remaining tax-exempt hospitals could not be included in the study because they were members of a hospital system that received approval from the IRS to submit a consolidated report for its member hospitals (e.g., Kaiser Permanente). As such, these hospitals did not file an individual Form 990 and Schedule H. Table 1 compares the study population to the universe relative to facility-level structural and operating characteristics. The study population somewhat underrepresented system-affiliated hospitals but generally was comparable to the universe. We also compared the study population to the universe relative to hospital location in nine US census regions and observed no significant differences.

We merged the hospital IRS filings with the 2009 AHA Annual Survey, the Area Resource File, and files from the Centers for Medicare and Medicaid Services. By combining

these data, we created a profile for each hospital that included its reported expenditures for community benefits, its institutional characteristics, and pertinent community and market characteristics.

**Community Benefit Measures:** We used the seven community benefit measures that hospitals reported for the 2009 Schedule H. These measures are charity care (i.e., subsidized care for those who meet the hospital's charity care criteria); unreimbursed costs for means-tested government programs; subsidized health services (i.e., clinical services provided at a financial loss); community health improvement services/community benefit operations (i.e., activities carried out or supported for the express purpose of improving community health such as conducting or otherwise supporting childhood immunization efforts); research; health professions education; and financial/in-kind contributions to community groups (i.e., to carry out any of the activities that are classified as community benefits in Schedule H) For purposes of comparability, we standardized each measure by dividing a hospital's reported expenditure by its own total operating expenses as reported on Form 990. Also, because Schedule H is a new source of hospital data, we took several steps to examine the validity of these data. These steps included comparing the expenditures hospitals reported on Schedule H with corresponding measures of service activity from independent data sources. For example, we examined the statistical relationship between a the expenditures a hospital reported for health professions education on Schedule H and the number of medical residents and other trainees that the hospital reported to the AHA in 2009. The correlation was .91. The other checks we undertook also supported the validity of Schedule H data (see online supplement).

To identify institutional-level and community/market-level characteristics that are associated with the provision of community benefits, we specified analytic models that entailed combining the seven community benefit measures into two distinct community benefit variables. For one variable we added together a hospital's reported contributions for those measures pertaining to direct patient care, namely charity care, unreimbursed costs for means-tested programs, and subsidized health services. For the other variable, we added together a hospital's reported contributions for the remaining measures pertaining to broader community service.

**Analysis:** We computed descriptive statistics for each of the community benefit measures. For the analytic models, we used multiple regression methods. We used two regression models, one for each type of community benefit measure: patient care and community service. We estimated both regression models using a generalized linear model.

For the regression models, the independent variables comprised institutional-level and community/market-level characteristics. Information for each independent variable is available in Table 3 and Table S1(see online supplement). Institutional characteristics pertained to a hospital's motivation (e.g., sole community provider) and capability (e.g., profit margin) to provide community benefits. Community/market characteristics pertained to the need for (e.g., percentage of population uninsured) and supply of community benefits (e.g., presence of public hospitals). We also accounted for the level of competitive pressures (e.g., market competition) that tax-exempt hospitals face, since such pressures may cause them to curtail their provision of community benefits. Consistent with previous studies, we defined a hospital's community/market area as the county in which a hospital is located.<sup>2</sup> In addition, we accounted for whether a hospital was located in one of 16 states that required hospitals to report



expenditures for a broad set of community benefits. Although there is no uniformity among these states in terms of how benefits are defined,<sup>12, 13, 14</sup> such requirements promote transparency and thus may motivate hospitals to provide higher levels of community benefits.

## RESULTS

Table 2 presents descriptive statistics for the IRS defined community benefit measures. Overall, tax-exempt hospitals expended, on average, approximately 7.5 percent of their operating expenses for these services and activities. However, there was considerable variation among hospitals in terms of the level of benefits provided. When hospitals were sorted into deciles based on the percentage of operating expenses devoted to community benefits, hospitals in the top decile spent on average 20% whereas those in the bottom decile spent on average 1% (see online supplement, Figure S1).

Of the expenditures reported for community benefits, hospitals devoted, on average, more than 85 percent to those services directly related to patient care (see Figure 1). About half of these expenditures went to subsidizing the cost of patients covered by means-tested government insurance programs, mostly Medicaid. For those activities that were not directly related to patient care, the great majority of expenditures were devoted to community health improvement activities and health professions education. This proportion of hospital expenditures for community health improvement and education is largely in line with the proportion previously reported by the Government Accountability Office in its investigation of tax-exempt hospitals' provision of community benefits in Indiana and Texas.<sup>8</sup>

Given the observed variation among hospitals in terms of the level of community benefits provided, we conducted further analyses to assess whether such variation reflects distinct patterns in hospitals' level of expenditures across the seven community benefit measures. That is, if a hospital provided a relatively high level of one benefit, is it likely that it provided a relatively high level of another benefit? Our analyses indicate otherwise. For example, fewer than 30 percent of the study hospitals were in the top quartile for three or more of the seven community benefit measures. Fewer than 12 percent of the study hospitals were in the top quartile for four or more of the measures. In addition, the correlation between the direct patient care and community services variables was only .01 indicating that hospitals providing relatively high levels of benefit in one domain of community benefit did not typically provide relatively high levels of benefits in the other domain.

Table 3 presents results from the regression analyses. For the patient care model, hospital expenditures were positively associated with state-level community benefit reporting requirements only. For the community service model, hospital expenditures were positively associated with two institutional-level characteristics -- teaching status and sole community provider designation – and also with state-level community benefit reporting requirements. For both models, there was also some evidence of broad geographic variation as hospitals in the west (the reference group) appeared, on average, to have relatively higher expenditures than hospitals in other regions of the country.

Since the regression analyses that included all hospitals in the study population revealed few determinants of hospital expenditures on community benefits, we also examined whether institutional and community characteristics distinguished hospitals that had relatively high levels

of community benefit expenditures from those that had relatively low levels of such expenditures. We used logistic regression where the dependent variable was specified to indicate whether or not hospitals had relatively high expenditures on community benefits (i.e., analyses were conducted for hospitals at the top and bottom 5% of the distribution, and also for the top and bottom 10%). These analyses did not reveal any pattern of differences between high and low providers of community benefits (see online supplement, Table S2).

To further investigate relationships between hospitals' provision of community benefits and key community characteristics, we sorted hospitals into three groups based on the percentage of uninsured residents in the communities they served and compared the level as well as pattern of expenditures among the three groups, as shown in Figure 2. Using analysis of variance, we found no statistically significant differences among these groups regarding either the level or pattern of expenditures. We obtained similar results for other community characteristics.

## **DISCUSSION**

The analysis presented in this manuscript offers a national assessment of the level and pattern of benefits that hospitals provided before the implementation of the ACA requirements. On a national basis, we found that hospitals devoted, on average, approximately 7.5 percent of their operating expenditures to community benefits. However, while 7.5 percent was the average level of hospital expenditure on community benefits, substantial variation existed among hospitals regarding both the level of benefits provided. Moreover, hospitals that provided

relatively high levels of one type of benefit were not likely to provide high levels of other types of benefits.

Among the many variables we examined that potentially underlie the inter-hospital variation in community benefits, few emerged as statistically significant. In particular, a hospital's provision of community benefits was not associated with either of two community-level socio-economic characteristics, the percentage of uninsured residents and per capita income. Previously conducted state-level studies have also reported no effect of these socio-economic characteristics on hospitals' provision of community benefits.<sup>2</sup> This suggests a lack of correspondence between community need and hospitals' provision of benefits. Moreover, it also raises questions regarding how hospitals, given their limited resources for such endeavors, decide on which community benefits to provide.

One variable that did exhibit a relationship with community benefit expenditures was state-level requirements for broad community-benefit reporting, which were significantly associated with higher levels of both patient care and community service benefits. As noted, these requirements promote transparency among hospitals regarding the provision of community benefits. However, as our study consisted of a cross-sectional analysis, the causal direction between the reporting requirements and provision of benefits cannot be firmly ascertained and thus requires further investigation.

The provisions of the ACA have important implications for the general pattern of hospital expenditures on community benefits. As the ACA mandate for individual health insurance is fully implemented, the need for hospital-based charity care should decline substantially. However, the required expansion of Medicaid coverage potentially will add financial pressure on

hospitals to cover patient care costs that exceed Medicaid payments.<sup>14</sup> Moreover, as study results reveal, community benefit expenditures have been largely directed to patient care services. While these expenditures create an important safety net for the uninsured and poor, they do not contribute to preventative care and population health, which are key priorities of the ACA. Accordingly, a possible response by tax-exempt hospitals to the ACA, including the previously noted provisions requiring community-needs planning, is a shift in expenditures toward community health improvement activities.

It should also be noted that the IRS' selection of community benefit measures has itself generated controversy. For example, some hospital industry officials have expressed strong objections to the IRS' decision to exclude bad debt and Medicare short fall from its set of community benefit measures.<sup>8</sup> Currently, the IRS requires hospitals to report these expenditures on Schedule H even though the agency does not classify them as community benefits. The inclusion of these measures would increase hospitals' average level of benefit expenditures substantially. Based on our analysis, the inclusion of bad debt alone would increase the average level of total hospital expenditures on community benefits from 7.5 percent to over 11 percent.

Finally, with the enactment of the ACA, tax-exempt hospitals are facing substantially new requirements for accountability and transparency regarding the community benefits they provide. Since 1969 when the IRS eliminated a requirement that tax-exempt hospitals provide charity care to the extent of their financial capability,<sup>15</sup> there has been much debate about whether these hospitals provide adequate community benefit to justify their tax exemptions. While this debate may well continue for the foreseeable future, the availability of new sources of

data and research for assessing the provision of community benefits among tax-exempt hospitals will at least make the debate a more informed one.

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Table 1: Characteristics of all tax-exempt, general hospitals and subgroup of hospitals included in this study



	<b>All tax-exempt general hospitals</b> (N=2894)	<b>Hospitals included in study</b> (N=1835)
Beds*		
<100	44.92%	45.18%
101-299	34.59%	36.73%
>299	20.49%	18.09%
Secular	83.97%	85.67%
Church 1	16.03%	14.33%
Independent*	44.23%	52.43%
System-affiliation <sup>2</sup>	55.77%	47.47%
Rural	40.92%	43.76%
Urban 3	59.08%	56.24%
Non teaching	92.67%	93.67%
Teaching <sup>4</sup>	7.33%	6.33%

\*p<0.05

1 Church affiliation refers to hospitals that were owned and operated by a religious organization. All other hospitals were classified as secular.

2 System affiliation refers to hospitals that were members of a corporate entity that owned two or more hospitals (i.e., multihospital systems). All other hospitals were classified as independent.

3 Hospitals classified as urban were those located within a metropolitan statistical area (MSA). All other hospitals were classified as rural.

4 Hospitals classified as teaching are those institutions that were members of the Council of Teaching Hospitals (COTH). All other hospitals were classified as non-teaching.

Table 2: Community Benefits as a Percentage of Hospital Operating Expenses

	<b>Mean</b>	<b>Standard Deviation</b>	<b>Hospitals at the 25th and 75th percentiles</b>
<b>Total</b>	7.45	6.41	3.88 -- 9.14
Charity Care	1.92	1.91	0.64 -- 2.57
Unreimbursed Costs for Means-Tested Government Programs	3.37	4.25	0.81 -- 4.65
Subsidized Health Services	1.10	2.79	0 --1.03
Community Health	0.36	0.98	0.02 -- 0.36

Improvement			
Cash/In-Kind Contributions to Community Groups	0.17	2.36	0 -- 0.09
Research	0.08	0.74	0 – 0
Health Professions Education	0.45	1.11	0 -- 0.32

Table 3: Association between institutional and community characteristics and community benefit

**Community Benefit**

	<b>Direct Patient Care</b>	<b>Community Service</b>
	Coefficient (SE) <sup>1</sup>	Coefficient (SE)
<b>Institutional Characteristics</b>		
Number of Beds	0.066 (0.113)	0.107 (0.060)
System-affiliation 2	-0.377 (0.329)	0.191 (0.174)

Network-affiliation <sup>3</sup>	-0.127(0.312)	-0.135 (0.165)
Case Mix Index 4	-1.87 (0.950)	0.699 (0.503)
Wage Index 5	-0.004 (0.044)	-0.015 (0.023)
Major Teaching Hospital 6	0.586 (0.680)	2.778 (0.360)**
Contract Managed <sup>7</sup>	0.388 (0.491)	-0.053 (0.260)
Church-affiliation <sup>8</sup>	-0.400 (0.441)	-0.178 (0.233)
Sole Community Provider 9	0.233 (0.520)	0.648 (0.275)*
High Profit Margin 10	0.173 (0.358)	0.147 (.191)
Negative Profit Margin	-0.325 (.412)	-0.152 (.218)
<b>Community/Market Characteristics</b>		
State-level Community Benefit Reporting Requirements 11	0.621 (0.264) *	0.406 (0.174)**
Per Capita Income for the Hospital's Community	0.000 (0.000)	0.000 (0.000)
Market Competition 12	0.098 (0.610)	-0.202 (0.323)
Percentage of Uninsured Individuals in the Hospitals' Community	0.051 (0.032)	-0.026 (0.017)

Percentage of Hospital Beds Controlled by For-Profit Hospitals in the Hospital's Community	-0.266 (1.277)	-0.482 (0.676)
Percentage of Hospital Beds Controlled by State or Local Government in the Hospital's Community	-0.266 (0.961)	-0.619 (0.509)
Urban Setting 13	0.360 (0.961)	-0.157 (0.216)
<b>Geographic Region</b>		
Northeast <sup>14</sup>	-2.039 (0.591)*	-0.706 (0.313)*
Midwest	-0.975 (0.537)	-0.653 (0.285)*
South	-1.606 (0.560)*	-0.540 (0.297)*

\*p<0.05 (two-tail tests) \*\*p<0.01

1 For continuously measured variables (e.g., number of beds), coefficients refer to the change in hospital community benefit expenditures (as a percentage of total operating expenditures) that corresponds to a one-unit change in the institutional or community variable. For categorical variables, coefficients refer to the average difference between hospitals comprising the categories, the one shown and the omitted reference group.

2 System affiliation refers to hospitals that were members of a corporate entity that owns two or more hospitals (i.e., multihospital system). The omitted reference group comprised independent hospitals.

3 Network affiliation refers to hospitals that participated in a strategic alliance or joint venture with one or more hospitals. Unlike system affiliation, these arrangements do not entail common ownership of the participating hospitals. The omitted reference group comprised hospitals that did not participate in networks.

4 A hospital's case mix index is the average diagnosis-related group weight for all of a hospital's Medicare patients. Medicare uses diagnostic related groups to compute case mix index values. Hospitals with case mix values above 1 have patients whose diagnoses are relatively more resource intensive than the national average. Hospitals with index values below 1 have patients whose diagnoses are relatively less resource intensive than the national average.

5 The Medicare wage index reflects geographic differences in hospital wage levels. A hospital's index value reflects the wage level for its geographic area compared to the national average hospital wage level.

6 Hospitals classified as teaching are those institutions that were members of the Council of Teaching Hospitals (COTH). The omitted reference group comprised non-teaching hospitals.

7 Contract managed refers to a hospital that had in place a contractual relationship with an outside company to manage its operations. The omitted reference group comprised hospitals that do not have such a contract.

8 Church affiliation refers to hospitals that were owned and operated by a religious organization. The omitted reference group comprised secular hospitals.

9 Sole community provider is a designation under the Medicare program for hospitals that meet at least one of several criteria (e.g., located at least 35 miles from other like hospitals). The omitted reference group comprised hospitals without this designation.

10 Profit margin was computed by subtracting a hospital's operating costs from its operating revenue and dividing the result by the operating revenue. High margin hospitals were defined as those that had margins above 3%; negative margin hospitals were those that had margins at or below zero; the omitted reference group comprised hospitals that had margins of greater than zero and not greater than 3%.

11 State-level reporting requirements refer to hospitals located in one of sixteen states that required hospitals to report expenditures for a broad range of community benefits in addition to charity care.

12 Market competition was measured in accordance with the Hirschman-Herfindahl Index (HHI), which for purposes of the study was computed by summing the squared values of each hospital's proportion of total hospital patients admitted to general, acute care hospitals within its market (defined as county). The theoretical range for the HHI is 0 to 1 where 1 indicates a monopoly (i.e., one firm in the market). For example, if there are two hospitals in a market, one with .25 share of total admissions and the other with .75 share of the admissions, the HHI would be .625 ( $.25^2 + .75^2$ ).

13 Hospitals classified as urban were those located within a metropolitan statistical area (MSA). The omitted reference group comprised rural hospitals.

14 For geographic region, the omitted reference group comprised hospitals that were located in the western region of the United States.

